

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-037850

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

9287

STATE FILE NUMBER

FILED SEP 27 1963

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS		c. CITY OR TOWN ST. LOUIS	
Length of stay in 1b 7 Hrs. 10 Min		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS-LITTLE ROCK HOSPITAL, INC.		d. STREET ADDRESS (If outside, give location) 2614 A. GEYER	
3. NAME OF DECEASED (Type or print) First EMMA Middle - Last MITCHELL		4. DATE OF DEATH Month SEPTEMBER Day 15 Year 1963	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12-14-1907
10a. USUAL OCCUPATION (Give kind of work done during last working life, even if retired) NOT EMPLOYED		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and state or country) DeSoto, Ill.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Rueben Buckels		13b. MOTHER'S MAIDEN NAME Rose Murray	
14. NAME OF HUSBAND OR WIFE Louis		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO.		17. INFORMANT Address Louis Mitchell, 2614a Geyer	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) 4201 DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			INTERVAL BETWEEN ONSET AND DEATH Four Hours
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour - a.m. - p.m. - Month, Day, Year -		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from April 1, 1962 to Sept. 15, 1963 and last saw him alive on Sept. 9, 1963 Death occurred at 8:00 AM on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Benjamin H. Chack, L.D.		22b. ADDRESS 1755 S. GRAND BLVD.	
22c. DATE SIGNED Sept. 14, 1963		23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	
23b. DATE 9/18/63		23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cem.	
23d. LOCATION (City, town, or county) St. Louis Co., Mo.		23e. (State)	
24. FUNERAL DIRECTOR ADDRESS MCLAUGHLIN FUNERAL HOME, ST: LOUIS, MO.		25. DATE RECD. BY LOCAL REG. SEP 17 1963	
26. REGISTRAR'S SIGNATURE Loan Smith, M.D.			

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION
BY AFFIDAVIT OF

VS 300
Rev. 4/59
1
2 223
3
4 1
5 1
6
7 1
8 1
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12 69-0
13

69.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

H. G. Jarvis

Licensed Embalmer No.

3384

P. O. Address

H. G. Jarvis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a-STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.